

**Finance Working Group:
Focus on Employer/Purchaser Strategies and Prescription Drug Costs**

Context

This report summarizes the Finance Group's discussion and evaluation of certain efforts to control the rapid growth of health care costs in two areas: employer/purchaser strategies to control health care coverage costs, and public and private efforts to control costs of prescription drugs.

These efforts to control increases in costs are trying to address perceived problems in the system as a whole – problems relating to efficiency and cost, quality, and access. Rather than focusing on payment to cost ratios in a particular provider context or other relatively confined issues, discussion of these topics requires a broader perspective on the system that includes consideration of consumers, purchasers, coverage plans, providers of all kinds, technology development, and utilization patterns. Evaluation of the techniques being tried in an effort to control cost growth must, to a degree, be premised on an evaluation of the system as a whole. The Finance Group believes that the system as a whole may be in serious jeopardy. Therefore, at the outset, the Finance Group wishes to outline its view of the context for the discussion.

When the Finance Group and this Task Force were getting underway over eighteen months ago, there was widespread concern about the financial condition of payers, notably our major nonprofit managed care organizations, and hospitals, nursing homes and other providers. Employers, on the other hand, were coming out of a period in the mid-1990s in which they had seen relatively low increases in health care coverage costs, and the percentage of Massachusetts residents without insurance was declining to among the lowest rates in the country. The economy was doing well. As alarms were sounded in this group and elsewhere that both private payers and providers were in real financial danger, premiums were increasing and employers and individuals were accepting those higher rates as the price of more stability in the system.

Now, after several rounds of significant premium increases, our HMOs appear to be in better financial shape.¹ Some of the additional money flowing into the system is filtering down to some hospitals and other providers.² While hospitals have been receiving more money, some may not be receiving enough to continue operations in the ways they would like. Other providers may also be receiving or are likely to receive more revenue as increasing amounts of dollars flow into the system; again, it is not clear whether the additional revenue will allow them to continue operations as they would like. Nursing homes have received some additional funding from Medicaid rate increases and many

¹ See for example Powell, Jennifer Heldt, "HMOs report in the black for quarter; Harvard Pilgrim sees gain", Boston Herald, November 9, 2001.

² See for example, Kowalczyk, Liz, "HMO rates climb again for 2002; Increases tied to drug costs, fees for care", Boston Globe, June 21, 2001, p.A1.

have restructured their crushing debt loads through the bankruptcy process, but these developments do not appear to have put them on solid financial ground. Medicare and Medicaid margins remain negative. In short, it does not appear that provider and payer financial conditions have improved commensurate with the increased level of expenditures on health care coverage and services.

What is more clear is that employers, individuals and the state are paying more for health care, and the significant annual cost increases are anticipated to continue for at least two years or so. As the economy has taken a downturn, employers and individuals are under more financial strain and many cannot afford substantial annual increases in health coverage costs. State revenue has taken a dramatic turn downward, and funding to support expansion of the Medicaid budget for substantial increases in provider rates or enrollment is simply not there.

The question presented by these changes in circumstance is, will the increases in funding flowing into the health care system be sufficient to avoid serious deterioration in the provider system and in access, before public and private payers reach the limit of their capacity to absorb the rate of cost increases from year to year? The Finance Group is not confident about the answer to this question, and believes that the Commonwealth – both public and private sectors – should prepare for at least two possible scenarios that are not mutually exclusive.

The first scenario, which the country has experienced in the past, is that the system will adjust to higher costs and higher cost increases. But the adjustment will not be easy and will carry severe consequences for many people and for state government. Some employers will not be able to afford the health insurance premium increases and will drop coverage altogether. Others will pass along a portion of additional costs to their employees. Some of those employees, in turn, will drop coverage as a result.³ At the same time, the state will experience increases in unemployment, uninsurance, Medicaid enrollment and uncompensated care, and will be under budget pressure to hold down increases in payments to providers, or to cut benefits or enrollment. These forces could contribute to further financial distress in the health care delivery system. While the system could adjust, as it has in the past, it is also possible that some providers may curtail services or close, putting even more pressure on those that remain and calling into question whether access to services will remain adequate.

The second scenario, which could grow out of or alongside the first, is that pressure will mount for government intervention. The Finance Group has already proposed that government engage in more active monitoring of the health care system through publication of data about health care utilization, costs and cost increases through an independent standing commission. The uncertainty caused by the economic downturn has highlighted the importance of government's oversight and monitoring function. Most Finance Group members have not recommended more assertive intervention by government through such actions as all-payer rate setting, more intensive regulation

³ Lambrew, Jeanne M. "How the Slowing US Economy Threatens Employer-Based Health Insurance" The Commonwealth Fund. November 2001.

through a health planning process, or other mechanisms. Some of these approaches have been tried in the past, with varying assessments of their success. Accordingly, while some Finance Group members would recommend more assertive government intervention, others are hesitant to recommend that course because they believe that the potential for such intervention to stabilize the system is not clear. Finance Group members do agree that it is appropriate for a small group of government leaders to engage in planning for what action government can or would take if the “worst case scenario” begins to materialize. “Worst case” can be understood as broad lack of access due to lack of insurance or financial resources or lack of sufficient providers. This recommendation is offered in the hope that it will prevent avoidable human suffering in the event conditions deteriorate.

Constraining Cost Growth

The Finance Group supports the many efforts underway to control cost growth and increase access to care. Several of these efforts focus on consumer education and empowerment through information and financial incentives. More and better information is a need the Finance Group has highlighted since its inception. With the right information and incentives, consumers and providers may, over time, improve the efficiency of the system, improve quality, reduce errors, and constrain, to a degree, the increases in health care costs.

At the same time, however, the Finance Group believes that these efforts are unlikely to succeed, in the short term, in controlling cost increases to any significant degree. Under current financing and delivery system arrangements, the health care system is likely to continue to generate higher costs at an increasing rate. Research and technology advances will continue to bring new and expensive treatments and interventions, including new prescription drugs. While those treatments, drugs and interventions may improve health outcomes, they will also increase costs. Even if current strategies succeed in changing consumer and provider behavior to yield greater efficiencies, those changes will be incremental and will probably not counteract rapid cost increases soon.

Even though the short-term outlook for health care cost increases looks somewhat bleak, the Finance Group believes that potential for change over a somewhat longer time frame may grow out of efforts of employers to engage consumers and providers in reducing the rate of health care cost inflation. With respect to prescription drugs, some efforts may be successful at obtaining somewhat lower prices and curtailing unnecessary use of the most expensive drugs. But significant governmental policy changes will probably be necessary to achieve substantial savings in the prescription drug arena, and the Finance Group believes the question of whether such policy changes can and should be implemented is worthy of a separate and focused analytical effort.

I. Employer/Purchaser Concerns and Strategies

After several years of little or no increase in health care coverage costs in the mid-1990s, employers have experienced several years of significant increases in premium costs, with

annual percentage increases recently in the double-digit range. [See Figure 1.] In Massachusetts, the average price of premiums is already well above the national average. [See Figure 2.] In recent years, as the economy flourished and employee retention was an important business goal, many employers did not pass much of the annual premium increases on to their employees. [See Figure 3.] In a strained economy with diminished corporate profits, this approach is likely to be unsustainable. It is not surprising, then, that the main challenge employers are focusing on is controlling the rate of increase in health care costs.

In the 1990s, employers relied on managed care plans to hold down the rate of increase in health care costs. Managed care seemed to offer the benefits of increasing the efficiency of the system, fostering appropriate utilization of services, and improving quality of care. In retrospect, managed care plans focused cost containment efforts on contract negotiations and low provider payments. Patients and providers resisted efforts to “manage” utilization of services, and some Finance Group members believe that employers failed to back managed care plans’ efforts when those objections surfaced.

Strategies

As costs have begun to increase again in the post-managed care backlash era, employers have re-engaged in the search for ways to improve the efficiency and effectiveness of the health care system. Some strategies involve employers’ assumption of more control over plan and provider network design. Most include increasing consumer responsibility for and control over care decisions and costs, and aligning incentives for physicians to direct care to the most efficient providers and to weed out unnecessary care. The main tool supporting these strategies is information – about quality, cost and efficiency of different providers and different treatment options. Employers agree that information alone may not propel consumers and providers to demand changes in the system, and that financial incentives for consumers and providers must be used as well.

Employer Direct Contracting with Networks. In an approach being used primarily outside of New England, some self-insured employers have established their own relationships with narrow networks of providers that agree to provide care to enrollees for substantially discounted fees. Employees who agree to use the restricted network have lower premiums than those who choose commercial plans. Combined with a defined contribution strategy, in which the employee bears the difference in cost between the lowest cost plan and higher cost plans, such a limited network plan may be an attractive option.

Efficiency Networks and Primary Care Provider Incentives. Some employers have had success in controlling costs of specialist services by using episode-of-care data to determine which specialists are the most efficient and providing this information to primary care physicians. Employers have then shared with primary care providers the cost savings derived from directing patient volume to the most efficient specialists. This technique has worked very efficiently in at least one large employer group in an area with

an oversupply of specialists. It is now being tried in other areas to determine its effectiveness under varying conditions.

Enhanced Disease Management. Disease management holds the promise of improving quality of care and decreasing costs over the long term, particularly in connection with the management of chronic conditions. In order to be effective, however, some have found that it must include one-on-one case management, which could add costs in the short term. In addition, the care management must extend to total patient care, not just the chronic condition. Because savings are likely to accrue over the long term, rather than in short order, employers most interested in this strategy tend to have more stable and older employee populations.

Activated Consumerism. Many of the strategies the Finance Group discussed focused on increasing consumer responsibility for choices about which plan, provider and treatment options they select. The long-term goal behind these “activated consumerism” strategies is that consumers having a greater personal investment in their health plan and their health care will demand greater cost-effectiveness and high-value re-engineering of plans and care processes. To bring such change about, however, consumers will need much more information about optimum treatments and the quality of providers and health plans than is currently available. More information is available every day with respect to self-management and treatment of conditions, and the Internet will facilitate the availability of information about plans and providers as it is developed. Consumers want more information about their conditions, but whether they will demand more and better information about providers and whether this will force greater efficiency in the system remains to be seen. Also, increasing employee financial responsibility often affects lower-income consumers disproportionately, requiring them to spend a greater percentage of their income on health care than higher-income consumers.

A common example of an “activated consumerism” strategy is the tiered co-payment structure featured in many prescription drug benefit plans.⁴ Some health plans have begun to offer tiered co-payment structures for other services, such as requiring a higher co-payment if an enrollee seeks treatment in a higher-cost teaching hospital rather than a community hospital. While many employers favor making consumers feel the financial consequences of choosing certain providers, some are uneasy about imposing higher co-payments if treatment in the higher-cost setting is recommended or medically necessary. The Finance Group believes that the application of the higher co-payment should be confined to those situations in which use of the more expensive facility is not necessary.

Defined contribution is another approach designed to make consumers more actively engaged in their choice of health plan, while limiting the employer’s cost to a set amount regardless of the plan the employee chooses. While this approach is gaining some acceptance, other employers would rather control their financial exposure by increasing the percentage of the premium all employees pay without setting a particular dollar limit

⁴ Under a tiered co-payment plan, a consumer’s out-of-pocket payment increases if he obtains a higher-cost drug where a lower-cost equivalent is available.

on the employer's contribution. This alternative does not "penalize" those employees with health care needs that lead them to select the most generous benefit package offered.

Another approach in the category of activated consumer strategies is use of a medical savings account along with a high-deductible plan that includes full coverage for primary and preventive care. This approach has the consequence of requiring more out-of-pocket payments from those employees who use health care services – in effect, a "sick tax." Some employers believe it is appropriate to assess higher costs on those who use medical services, and to encourage them to choose providers and treatments in a cost-conscious manner. This rationale seems to run afoul of the insurance principle (i.e., spreading the risk and cost of health care needs broadly), at least for services falling within the cost range of the high deductible, but is not inconsistent with the gradual replacement of health insurance with pre-paid health care that we have seen over the last ten years in Massachusetts.

Quality Focused Techniques. Employers are concerned about unnecessary costs arising from medical errors and sub-optimal care. Many believe that the most promising strategy to reduce health care costs and inflation is to focus on improving quality. The Leapfrog Group has embraced three features of hospital care that are associated with better outcomes: use of high-volume providers for certain complex procedures; use of hospital-based intensivists in ICUs; and use of computer prescription order entry systems. [see attached Fact Sheet on the Leapfrog Group] Each of these measures is supported by evidence that they improve outcomes, and whether or not a particular hospital meets the standards (or "leaps") is easily measured and verified. The Leapfrog strategy is to report which hospitals meet the three "leaps" and to induce consumers to use those providers for services that can benefit from the "leaps."

In Massachusetts, the Group Insurance Commission has joined the Leapfrog group and has requested that health plans report on whether the hospitals in their networks meet the three "leaps." Most hospitals have refused to comply with the reporting request, arguing that the three "leaps" are not necessarily the best measures of quality.⁵ Hospitals would prefer to report on initiatives hospitals are currently engaged in that are improving quality of care and reducing medical error (irrespective of the three "leaps").

Some Finance Group members are frustrated by hospitals' refusal to report. However, they also acknowledge a significant problem with relying on the Leapfrog "leaps": it is likely that only some of our expensive teaching hospitals will meet all the "leaps" and reporting on these particular measures may have the effect of encouraging patients to use those hospitals even for procedures that could be performed safely in less costly settings. While medical error reduction is likely to lower costs in the long run, the Finance Group has found that overuse of teaching hospitals is one of the most significant drivers of cost in the Massachusetts health care system. Most Finance Group members would be more supportive of the Leapfrog initiative if it included measures that would highlight the preferability of community hospitals for some procedures. Also, some Finance Group members point out that the move to encourage use of higher cost hospitals for some

⁵ Powell, Jennifer Heldt, "Hospitals Thwart Rating Plan," Boston Herald, October 29, 2001.

complex procedures directly counters the incentives in newer health plans that impose higher co-payments for using those facilities.

To summarize, employers are:

- Increasing consumer financial responsibility for coverage and coverage choices.
- Increasing consumer financial responsibility for care choices.
- Trying to improve the information about quality and cost that is available to help consumers make prudent choices.
- Exploring lower-cost, self-insured alternatives to commercially available managed care and insurance plans.
- Developing strategies for incenting providers to use resources more efficiently and to reduce medical errors.

The Finance Group supports these pursuits, though it is not confident they will succeed in the short term in constraining cost growth system-wide. Some will, at a minimum, reduce the increases that employers feel as they redistribute a share of the increase to employees. In addition, some Group members believe there is a chance that consumers, when faced with greater responsibility for payments and costs, will “rebel” and will call for more government intervention to simplify and finance the system.

II. Prescription Drug Costs and Strategies

One of the most significant drivers of health care cost increases in recent years is prescription drug costs.⁶ The phenomenon of skyrocketing prescription drug costs in the United States has been well documented and widely reported, so only a brief summary of main points is included here. [See Figure 4.]

- The high cost and high utilization of new drugs are more significant factors than increases in prices for existing drugs. [See Figure 5.]
- The benefits of some new drugs over previously available therapies are hard to quantify. Drugs may substitute for other more invasive or costly services, but little data is available to confirm that possibility. Other countries, however, have implemented systems by which to evaluate the clinical and cost-effectiveness of a new drug before including it on the country’s formulary.⁷

⁶ In 2000, hospital spending outstripped prescription drug spending as the largest contributor to medical cost increases. Center for Studying Health System Change, Data Bulletin, September, 2001. Still, the annual percentage increase in prescription drug expenditures was four times that for hospital expenditures. Some observers expect prescription drug costs to resume their dominant position as the largest contributor to medical cost increases next year. While this is not yet determined, a Robert Wood Johnson Foundation media release forecasted that prescription drugs would continue to rise, along with hospital spending, while physician spending would remain flat.

⁷ Birkett, Donald J., et. al. “A Cost-Effectiveness Approach to Drug Subsidy and Pricing In Australia” Health Affairs. Vol. 20: no. 3, May/June 2001. and Menon, Devidas. “Pharmaceutical Cost Control In Canada: Does It Work?” Health Affairs. Vol. 20, no. 3 May/June 2001.

- The number of prescriptions per person has increased in recent years, particularly among those who were already relatively high users. [See Figures 6 and 7.]
- Utilization of new, high-cost drugs is encouraged by direct-to-consumer (DTC) advertising, on which drug manufacturers spend increasing amounts of money. [See Figure 8.]
- Anecdotally, physicians feel it is not worth the time and effort it would take them to dissuade consumers who request brand name drugs even when it is not medically necessary.
- Some new drugs offer treatment for conditions that were previously not treatable, fewer side effects than previously available options, and better ability to manage chronic conditions than previously available options. Drug therapy has improved outcomes for example, for many people with asthma, diabetes, depression and heart disease.
- Federal patent law guarantees a “monopoly” for a limited time, allowing producers to charge as much as the market will bear for their products; other countries impose price controls.⁸
- Some drugs that are available only by prescription in the U.S. are available over-the-counter in other countries. For example, one may find Claritin alongside Sudafed at the local pharmacy in Canada.
- Drug manufacturers argue that corporate profits are needed to fund research, but they also fund marketing and lobbying efforts. [See Figure 9] Federal research funding also enables research that leads to drug development, though the continued availability of current levels of such funding is not assured.

Heightening the impact of rising costs, insurance coverage for prescription drugs is shrinking, particularly for seniors and others who depend on Medicare and Medicare supplements.

- A 1997 federal law pre-empted a Massachusetts law that required Medicare HMOs to offer an unlimited prescription drug benefit. Since then, Medicare + Choice HMOs have offered lower levels of benefits, with higher premiums; many have withdrawn altogether. Premiums for Medigap insurance that offers drug coverage are expensive and increasing rapidly. [See Figure 10.]
- Medicare continues to lack any coverage for outpatient prescription drugs.

⁸ Menon, Devidas. “Pharmaceutical Cost Control In Canada: Does It Work?” Health Affairs. Vol. 20, no. 3 May/June 2001.

- Many employers are cutting back on retiree health coverage, which many seniors rely on for prescription drug coverage.
- Seniors are particularly dependent on prescription drugs to manage chronic diseases and conditions, which they experience at a higher rate than younger populations. The number of seniors with high drug cost needs has increased rapidly in recent years.⁹

Strategies

A number of efforts are underway to try to help control or defray the high cost of prescription drugs, particularly for seniors, thereby increasing access. Some techniques seek to control costs by controlling or changing utilization, while others seek to control costs by lowering prices. Some combine both strategies.

Prescription Advantage. Most notably, Massachusetts has enacted the Prescription Advantage Program, a state-supported insurance plan for seniors and people with disabilities, with subsidies for low-income enrollees. The Prescription Advantage Program replaced two subsidy programs. The structure of the plan is complex, including a number of different income level classifications, each entitled to a different level of subsidy. The program uses negotiated discounts with manufacturers and a tiered co-payment structure. As such, it combines elements designed to control prices and utilization.

What separates this plan from others in the country is that it offers unlimited coverage, after a maximum out-of-pocket expenditure, to all seniors and people with disabilities, regardless of income. While premiums and co-payments vary in relation to income, all enrollees have exposure only up to the out-of-pocket maximum, which is fixed at the lower of \$2000 or 10% of Gross Annual Household Income per year. [See attached summary] The benefit the Prescription Advantage Program offers is very good, even for high-income people. One reason people have not enrolled in greater numbers is apparently their lack of confidence that the state will continue the plan, according to a survey conducted by the program's administrator.

While the Finance Group lauds the Prescription Advantage Plan goals and believes that Massachusetts has stepped up more than any other state to help defray the high cost of drugs for this population, it is concerned that the current business model of the plan may not be sustainable in the long term. Finance Group members believe that certain elements in the program design – notably the combination of the expansive benefit, substantial (albeit limited) out-of-pocket responsibility for premiums, co-payments and deductibles, and the lack of any constraint on when an individual joins or leaves the plan – present the risk that individuals will hold off enrolling in the plan until they are certain that the cost of their drug needs will exceed their financial exposure under the plan. This

⁹ See Thomas, C.P., Ritter, g. and Wallack, S.S., “Growth in Prescription Drug Spending Among Insured Elders,” *Health Affairs* 20:5, September/October 2001, pp.265-276 (showing increasing prescription drug use among insured elders with chronic conditions).

violates the principle of insurance, which functions by using premiums paid by enrollees who end up not using the benefit to finance expenses for those who do. If this dynamic materializes, in effect, all enrollees would be benefiting from state subsidies (rather than only those that are expressly entitled to subsidies due to low income levels), and the program would require greater state appropriations each year to continue operating. On a more hopeful note, the Finance Group has been advised that there may be an opportunity to combine certain parts of the Prescription Advantage Plan with the Medicaid program, thereby obtaining federal financial participation. The Finance Group has not reviewed the plan's structure and projected expenditures in detail, and advises that the plan administrators conduct such a review to determine whether changes in the plan's design are appropriate and whether there is an opportunity to capture federal revenue.

Medicaid. The Massachusetts Medicaid program is engaged in several initiatives designed to reduce expenditures for prescription drugs, which are expected nearly to outstrip expenditures for hospital and physician services combined by 2003. [See Figure 11.] These strategies together should address both utilization and price. Federal law requires Medicaid programs to cover all drugs of manufacturers that have entered into rebate agreements with the federal government. Virtually every manufacturer has such an agreement in place, so virtually all drugs must be covered by Medicaid. In addition, there are limitations on the copayments Medicaid programs may require, and an enrollee's failure to pay a co-payment does not allow a pharmacist to refuse to fill a prescription. As a result, Medicaid programs may not construct restrictive formularies or tiered co-payment systems to control costs, as many private plans have done.

Most cost control tools available to the Medicaid program are administrative. Massachusetts is currently pursuing more aggressive prior authorization requirements for use of brand-name drugs where a generic equivalent is available; possible development of a "preferred" list of brand name drugs, subject to the availability of additional rebates from certain manufacturers; investigating pricing policies to ensure that Medicaid receives the lowest price, as required by law; and exploring the use of mail-order service for maintenance drugs. The Medicaid program is also tracking prescribing patterns and communicating directly with providers whose patterns fall far outside norms. At this point, Massachusetts has not opted for more Draconian measures being taken in some state Medicaid programs, such as imposing an arbitrary limit on the number of prescriptions an enrollee may receive in a month.

Multi-State Legislative Association and Bulk Purchasing. Members of the state Legislature are participating in an interstate association with the goal of achieving savings on prescription drugs for public and private payers. The Northeast Legislative Association on Prescription Drug Prices, which has representatives from eight states, has agreed to work together to aggregate purchasing of prescription drugs and to collaborate on physician and consumer education about drug usage. The Association has recently arranged for support to help it in analyzing approaches including bulk purchasing and pharmacy benefit management techniques. The Massachusetts Legislature has tried to encourage bulk purchasing by the state, but that effort has encountered legal and logistical barriers.

Discount Cards. Several private organizations have offered a discount program under which enrollees, in exchange for a modest enrollment fee, would be entitled to certain negotiated discounts off the market price of certain drugs purchased at certain pharmacies. These programs must have adequate networks and meaningful discounts on a range of frequently used drugs to be effective.

Physician Education Programs. Some health plans, including the Massachusetts Medicaid program, have begun providing data to physicians about their prescribing patterns and the extent to which they deviate from norms. This data is often combined with educational information about the benefits of certain drugs. The approach is sometimes called “counter detailing,” in reference to the “detailing” programs of marketing to physicians some pharmaceutical companies have designed.

Purchasing Abroad. Several mechanisms are available to individuals to purchase prescription drugs abroad, including organized bus trips and web sites. The benefit, of course, is the lower retail prices available in other countries. Widespread systematic use of these mechanisms, however, could give rise to other problems, such as depletion of drug supplies in other countries or deliberate limits on such supplies being imposed by drug manufacturers. In addition, there may be quality assurance problems related to non-FDA-approved drugs purchased abroad.

Outlook

The Finance Group is hopeful that the Prescription Advantage Program, with modifications as necessary, will facilitate access to prescription drugs for seniors and people with disabilities. With respect to the issue of decreasing or holding down increases in cost, the Finance Group does not believe that the strategies currently in use are likely to have a lasting or significant impact. For that level of intervention, federal government action will probably be required. The Finance Group believes that only the federal government has the authority and the power to change patent protection, approve use, and regulate interstate commerce issues such as price-setting.

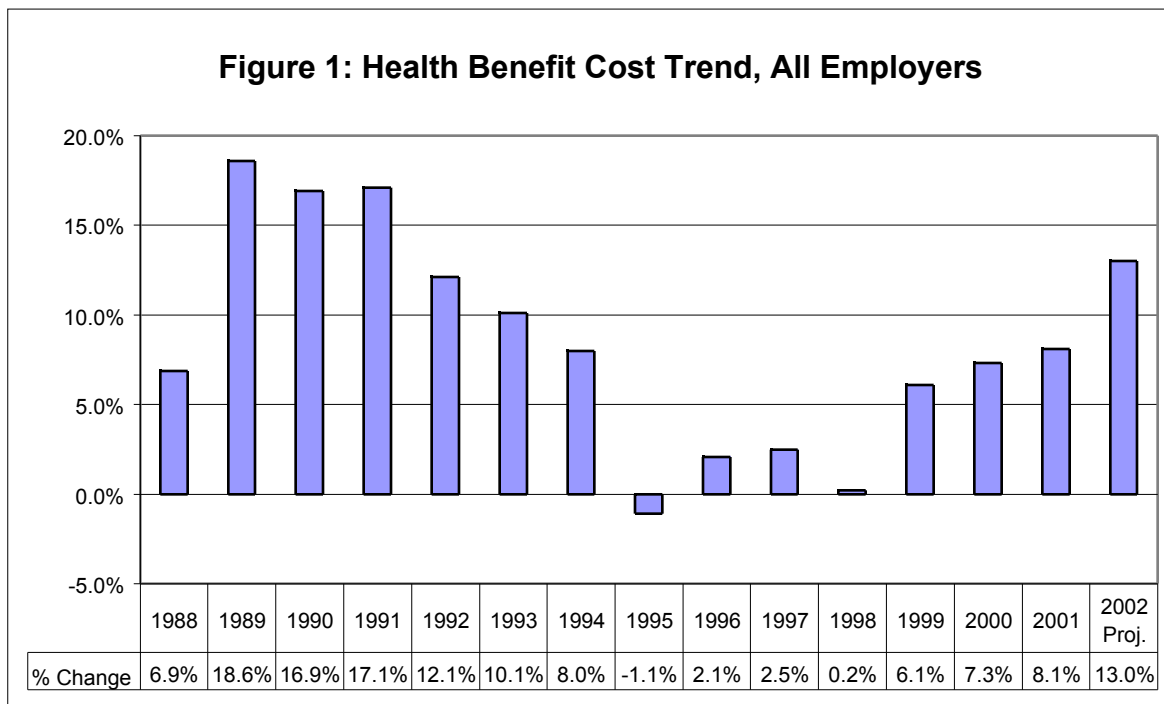
One member of the Finance Group has suggested that the federal or state government adopt a more aggressive regulatory approach to prescription drug manufacturers while establishing a plan for universal access to prescription drugs. Under this approach, prices paid for drugs would be lowered to levels approximating production cost, but people who currently lack insurance coverage would be enrolled in a government-sponsored program that would pay for drugs on their behalf. At its inception, the program envisioned would keep drug manufacturers’ revenues roughly whole because the increase in patient volume would probably counteract the decrease in unit price. Going forward, incremental revenue would depend on the prices set by the government payer, which would take into account the cost of research leading to the drug’s development.

Most members of the Finance Group find this approach too reliant on aggressive government regulation. One member of the Group has suggested that an alternative

approach would be to have the state establish itself as a wholesale purchaser of drugs, presumably through aggregating state and private purchasing. Most members of the Finance Group are more willing to consider assertive government intervention in the health care system, and particularly with respect to prescription drug costs, than they would have been several months ago. For significant and long-term gains in controlling prescription drug costs, the Finance Group believes that such intervention may need to come from the federal government. To determine whether additional state efforts would succeed in bringing drug costs and cost increases under better control, the Finance Group recommends a separate and focused analytical effort, building on the effort of the Northeast Legislative Association on Prescription Drug Prices. [See attached summary of state options under existing federal law.]

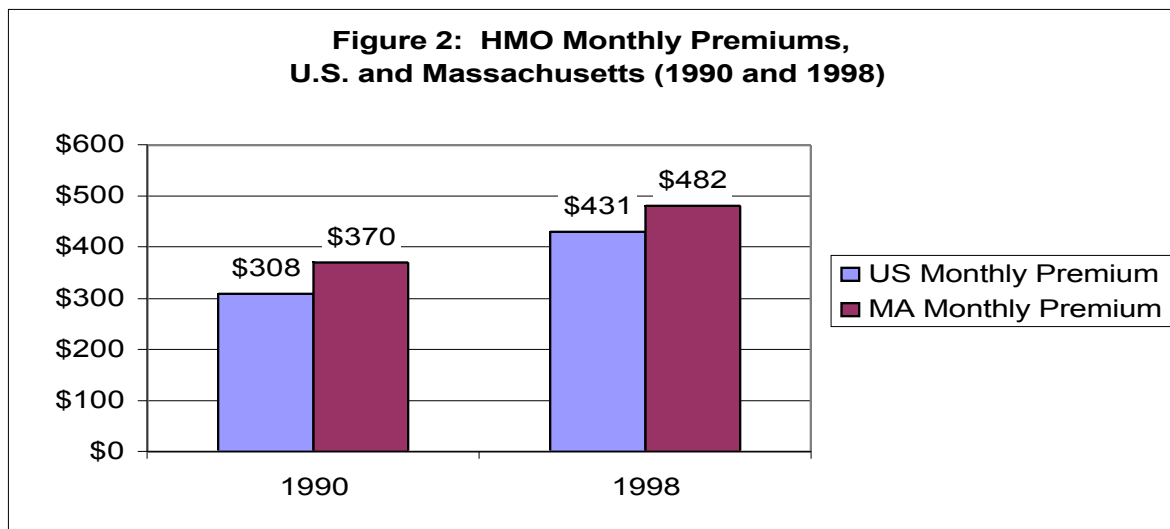
Conclusion

The Finance Group's examination of these two areas have left it believing that few strategies currently underway are likely to succeed in the near term. Therefore, it is likely that costs will continue to increase and that, in challenging economic times, numbers of people without insurance will increase. There is hope that some of the efforts underway to engage consumers in the effort to reduce costs and increase system efficiency and quality will lead to some savings in the longer term. It is also likely that pressure for government intervention will increase. The Finance Group has recommended, and continues to recommend, that government embrace at least an enhanced role in collecting, analyzing and publishing data and information about the health care system. That information would include analysis of costs, quality and utilization patterns, with the goal of facilitating agreement on best practices and improving the efficiency of the system overall. An independent commission could perform this kind of general oversight, monitor key indicators, inform policy makers on trends and issues, and provide an early warning of potential instability. In addition, the Finance Group recommends that a small group of state leaders engage in planning for responses in the event the system becomes more unstable in the economic slow-down we are currently experiencing.



Source: William M. Mercer, Incorporated

Premium rates increased rapidly in the early 1990's, leveled off in the middle of the decade, and now have begun to rise again.



Source: "Massachusetts Health Care Trends: 1990-1999," Massachusetts Division of Health Care Finance and Policy, October, 2000.

Average monthly HMO premiums in Massachusetts have consistently exceeded U.S. averages.

Figure 3:

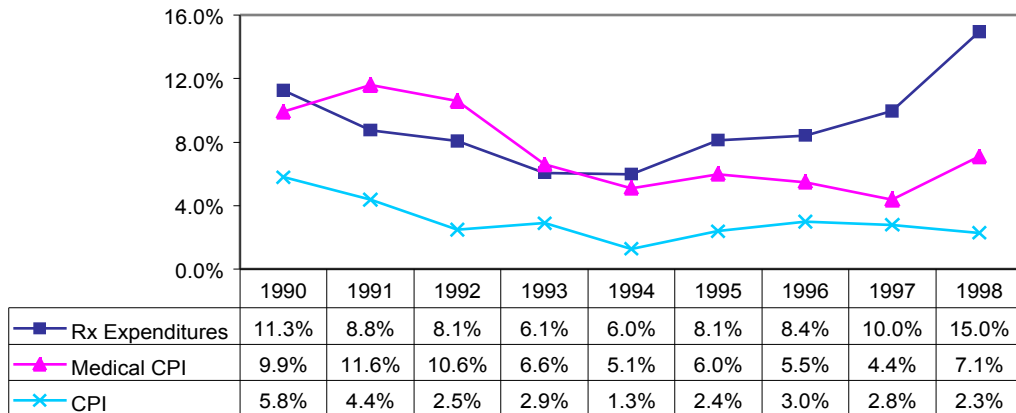
	1999	2000
% Employers planning to increase employee contributions	21%	40% / 58%*
% Employers planning to increase other cost-sharing	9%	17% / 26%*

**Mercer Survey of Employer-Sponsored Health Plans 2000*

Source: William M. Mercer, Incorporated

More employers planned to increase the amount of health care costs passed on to employees in 2000 than in 1999.

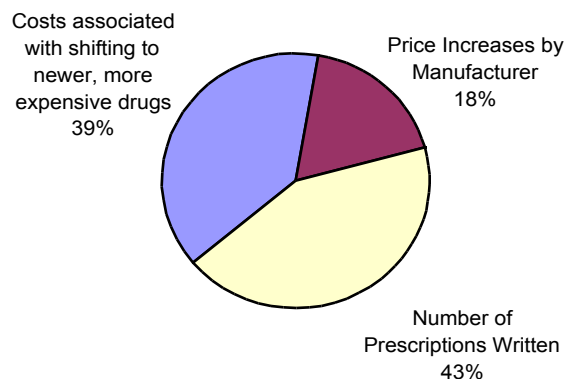
Figure 4: Annual Change in MA Prescription Drug Expenditures and Boston Regional Inflation Rate



Source: Health, United States, 1999, US Department of Health and Human Services; US and Boston Regional Consumer Price Index 2000, US Bureau of Labor Statistics. Medical CPI and CPI are for the "Boston-Brockton-Nashua, MA-NH-ME-CT" region.

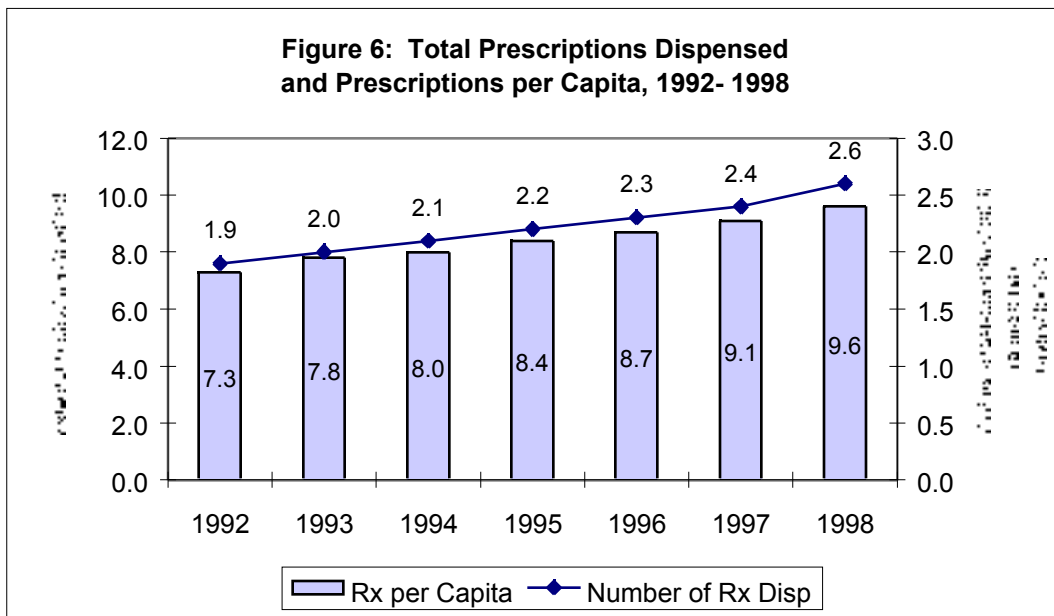
Throughout the 1990s Massachusetts prescription drug expenditures increased faster than general inflation; from 1995 through 1998 prescription drug expenditures also increased faster than overall medical inflation.

Figure 5: Relative Factors Contributing to Rising Prescription Drug Expenditures, 1993-1998



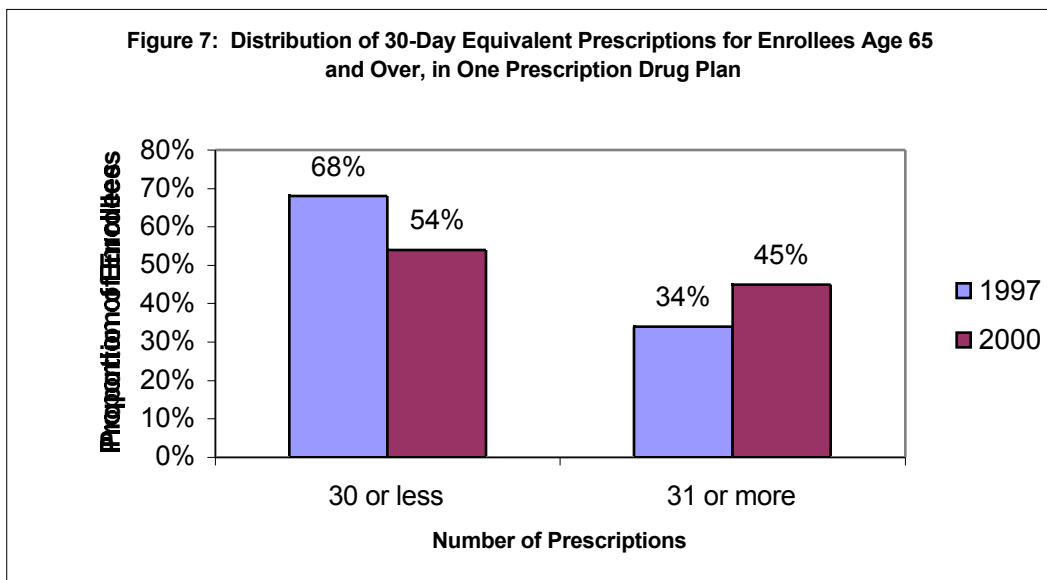
Source: Kreling, David H., et. al. Prescription Drug Trends, A Chartbook. University of Wisconsin - Madison and the Kaiser Family Foundation. July 2000.

Only 18% of the increase in prescription drug expenditures is attributable to price increases. 43% of the increase is attributable to an increase in the number of prescriptions written and 39% is attributable to the availability of newer and more expensive drugs. Many of these newer drugs are either more effective or have fewer side effects than drugs previously available.



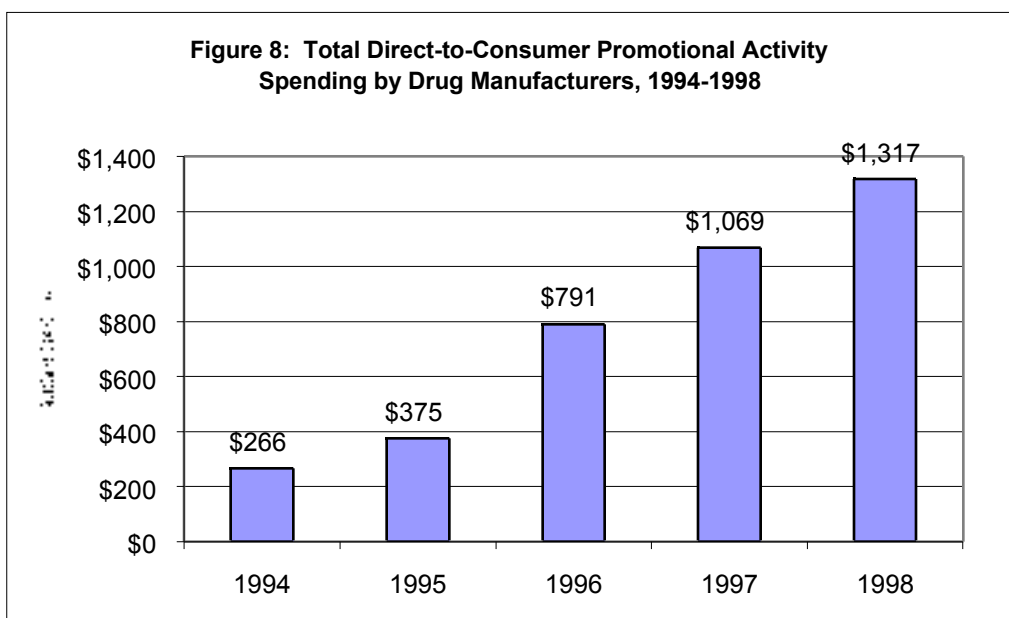
Source: Kreling, David H., et. al. Prescription Drug Trends, A Chartbook. University of Wisconsin - Madison and the Kaiser Family Foundation. July 2000

The number of prescriptions written is increasing overall and per capita.



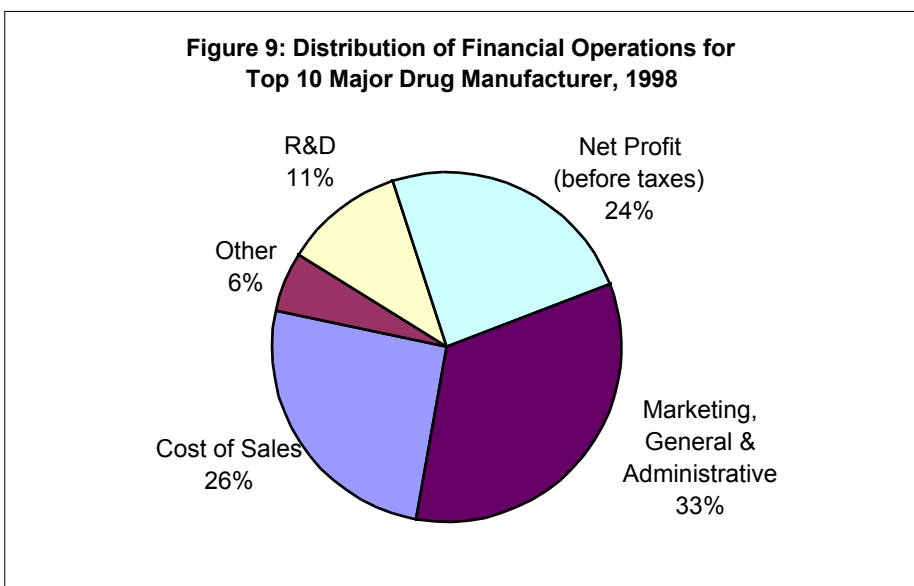
Source: Wallack, S.S., et. al. "Recent Trends in Prescription Drug Spending for Insured Individuals Under 65 and Age 65 and Older" Schneider Institute for Health Policy. July 30, 2001. Data presented for enrollees age 65 and over in AdvancePCS.

A greater proportion of elderly people are receiving a very high number of prescriptions than previously. The elderly use far more prescription drugs than younger people.



Source: Kreling, David H., et. al. Prescription Drug Trends, A Chartbook. University of Wisconsin - Madison and the Kaiser Family Foundation. July 2000

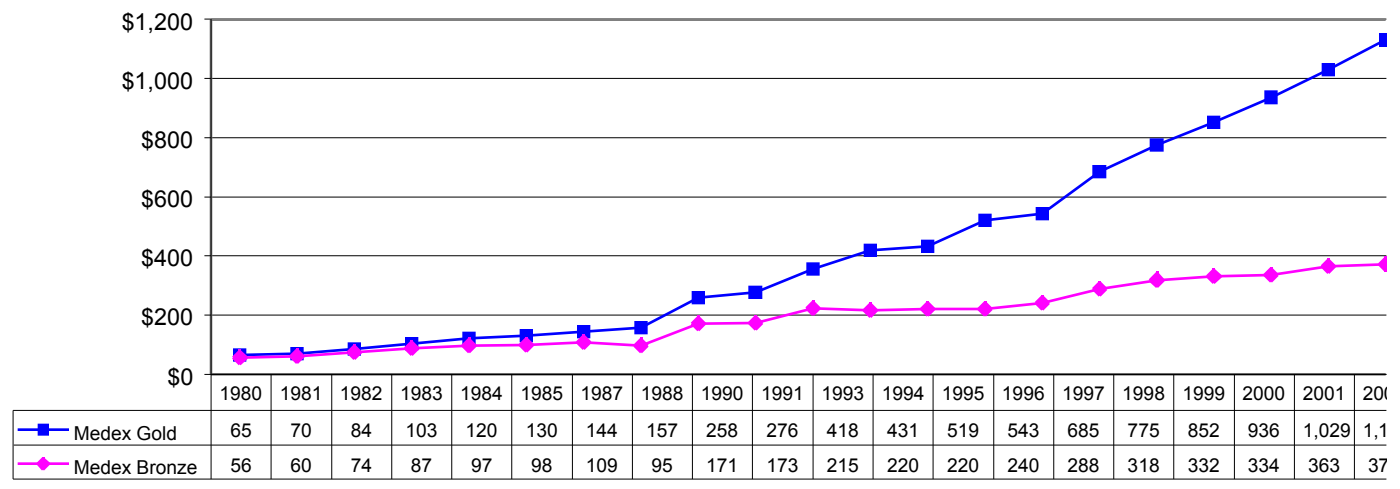
Drug manufacturers' spending on direct to consumer promotional activities increased rapidly after the U.S. Food and Drug Administration revised guidelines for advertising prescription drugs in 1995.



Source: Kreling, David H., et. al. Prescription Drug Trends, A Chartbook. University of Wisconsin - Madison and the Kaiser Family Foundation. July 2000.

Major drug manufacturers' net profits exceed research and development expenditures.

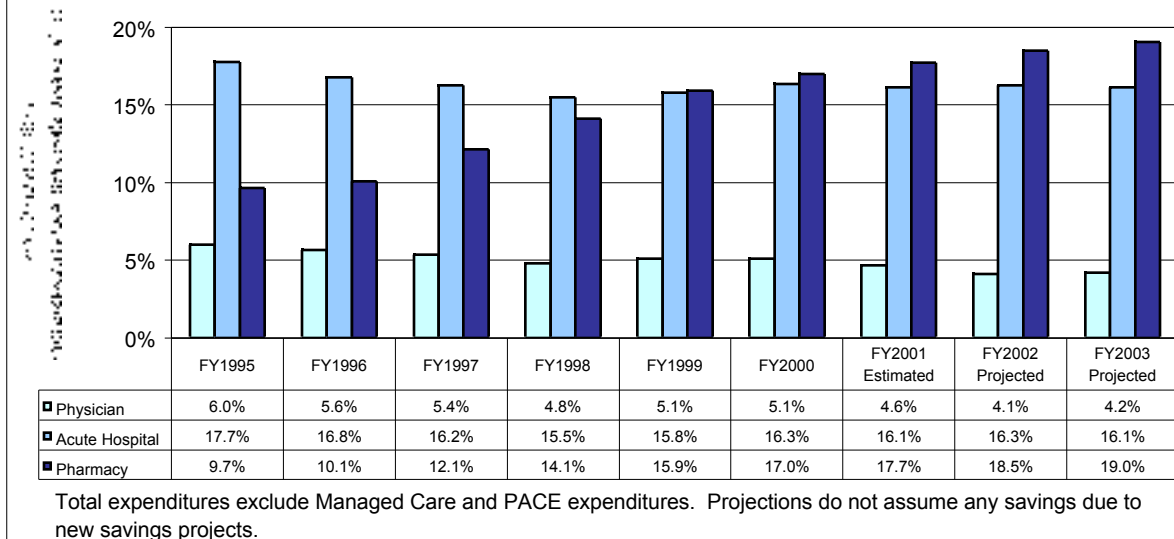
Figure 10: Blue Cross Blue Shield of Massachusetts Medex Gold and Medex Bronze Premium rates



Source: Division of Insurance

Blue Cross Blue Shield's Medex Gold and Medex Bronze plans are identical, except that Medex Gold includes drug coverage while Medex Bronze does not. Medex Gold premiums are increasing much faster than Medex Bronze.

Figure 11: MassHealth Physician, Acute Hospital, and Pharmacy Expenditures as a Percentage of Total MassHealth Expenditures



Source: Division of Medical Assistance

Massachusetts Medicaid spending on pharmaceuticals exceeded spending on acute hospital services in 1999. Pharmaceutical spending is expected to outstrip spending for both acute hospital and physician services combined sometime in the next few years.

Attachments:

The Leapfrog Group: Fact Sheet

Prescription Advantage: Program Description and Rate Schedule

“Chart 6: Analysis of State Drug Assistance Options Under Federal Law”
from the National Conference of State Legislatures

FACT SHEET



The Business Roundtable's "Leapfrog Group"

The Leapfrog Group is a Business Roundtable-sponsored commitment to mobilize employer purchasing power to initiate breakthrough improvements in the safety of healthcare for Americans. It is a voluntary program aimed at mobilizing large purchasers to alert America's health industry that big leaps in patient safety and customer value will be recognized and rewarded.

A 1999 report by the Institute of Medicine (IOM) found that up to 98,000 Americans die every year from preventable medical errors made in hospitals. The report recommended that large purchasers provide more market reinforcement for quality and safety. It is precisely because the scientific literature shows that so many medical errors are preventable that the BRT is encouraging employers to take safety "leaps" forward with their employees, retirees and families by rewarding the hospitals that implement significant safety improvements.

The Leapfrog Group's growing consortium of Fortune 500 companies and other large private and public health care purchasers provide health benefits to more than 26 million Americans; Leapfrog members and their employees spend more than \$46 billion on health care annually. Under Leapfrog, employers have agreed to base their purchase of health care on principles encouraging more stringent patient safety measures. The Leapfrog Group's initiatives have the potential to save up to 58,300 lives and prevent up to 522,000 medication errors each year (Birkmeyer, 2000).

Leapfrog's Mission

The Leapfrog Group's mission is to trigger a giant leap forward in quality, customer service and affordability of health care of all types by:

- Making the American public aware of a small number of highly compelling and easily understood advances in patient safety; and
- Specifying a simple set of purchasing principles designed to promote these safety advances, as well as overall customer value.

This effort is rooted in four foundational ideas:

- American health care remains very far below obtainable levels of basic safety and overall customer value.
- The health industry would much more rapidly improve if purchasers better recognized and rewarded superior safety and overall value.
- Voluntary adherence to purchasing principles by a critical mass of America's largest employers would provide a large jump-start and encourage other purchasers to join.
- These principles should not only champion superior overall value, but specifically focus on a handful of specific innovations offering "great leaps" in basic patient safety to maximize media/consumer support and adoption by other purchasers.

Initial Leaps in Patient Safety

The Leapfrog Group has identified three initial hospital safety measures that will be the focus of health care provider performance comparisons and hospital recognition and reward. Based on independent scientific evidence, the initial set of safety measures includes: computer physician order entry; evidence-based hospital referral; and intensive care unit (ICU) staffing by physicians trained in critical care medicine.

- **Computer Physician Order Entry (CPOE)** – With CPOE systems, physicians enter medication orders via computer linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by **more than 50%**.
- **Evidence-Based Hospital Referral** – By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria – such as the number of times a hospital performs these procedures each year – research indicates that a patient’s risk of dying could be reduced by **more than 30%**.
- **ICU Physician Staffing** - Staffing ICUs with physicians who have credentials in critical care medicine has been shown to reduce the risk of patients dying in the ICU by **more than 10%**.

This initial list is based on four primary criteria: (1) There is overwhelming scientific evidence that these safety leaps will significantly reduce avoidable danger. (2) Their implementation by the health industry is feasible in the near term. (3) Consumers can readily appreciate their value. (4) Health plans, purchasers or consumers can easily ascertain their presence or absence in selecting among health care providers. These safety leaps are intended as a practical first step in using purchasing power to improve patient safety.

The Leapfrog Group member companies have all agreed to adhere to the following four purchasing principles in buying health care for their enrollees:

- 1) Educating and informing enrollees about patient safety and the importance of comparing health care provider performance, with initial emphasis on the Leapfrog safety measures;
- 2) Recognizing and rewarding health care providers for major advances in protecting patients from preventable medical errors;
- 3) Holding health plans accountable for implementing the Leapfrog purchasing principles and;
- 4) Building the support of benefits consultants and brokers to utilize and advocate for the Leapfrog purchasing principles with all of their clients.

Because the health industry needs time to meet these standards, Leapfrog purchasers will work with the provider community to arrive at *aggressive but feasible* target dates for purchaser application of the standards.

The Business Roundtable

The Business Roundtable is an association of chief executive officers of leading corporations with a combined workforce of more than 10 million employees in the United States. The chief executives are committed to advocating public policies that foster vigorous economic growth; a dynamic global economy; and a well-trained and productive U.S. workforce essential for future competitiveness.



**Prescription
Advantage**

Massachusetts, Now You're Covered.

Prescription Advantage provides coverage for most prescription drugs to Massachusetts seniors and eligible people with disabilities.

Program Description

Prescription Advantage is a prescription drug insurance plan, backed by the Commonwealth of Massachusetts, that began operating on April 1, 2001. This plan is designed to provide protection against the financial impact of high prescription drug costs. For Massachusetts residents aged 65 and older, eligibility is open, regardless of income. Residents under age 65 may also be eligible. See the "Eligibility Guidelines" section on page 2 for more details. Prescription Advantage is administered by the Massachusetts Executive Office of Elder Affairs.

- Prescription Advantage provides prescription drug coverage only. It provides no other medical coverage.
- It is your responsibility to secure information regarding the relationship between your current prescription drug coverage and Prescription Advantage to determine what coverage (either or both) is right for you.

Benefits

- Prescription Advantage covers most prescription drugs, including insulin and disposable insulin syringes with needles.
- There is no dollar limit to the prescription drug benefit provided to eligible enrollees; however, Prescription Advantage provides benefits only after you use up all prescription drug coverage from other plans.
- Out-of-pocket expenses for deductible and co-payment amounts paid under this plan per enrollee per year will not exceed \$2,000 or 10% of your gross annual household income, whichever is less.
- Prescription Advantage coverage always begins on the first of the month.

Premium Assistance

- Based on your income, you may qualify for a state subsidy to pay all or part of your premium and deductible, as well as qualify for reduced co-payments. Please see the enclosed rate schedule on page 12.
- If you would like to be considered for premium assistance, verification of your gross annual household income is required.
- For anyone under age 65 who is applying, verification of gross annual household income is required.
- If you and/or any member of your household files Federal income taxes, you must include copies of the most recent Federal income tax returns as verification of gross annual household income.

Eligibility Guidelines

You are eligible for Prescription Advantage if you are a resident of Massachusetts, do not have prescription benefits under MassHealth or CommonHealth (Medicaid), and if you:

- Are 65 years of age or older; **OR**
- Were enrolled in the PHARMACY Program or PHARMACY Program Plus as of March 31, 2001; **OR**
- Are under age 65, have a disability, either do not work or work 40 hours or fewer per month, and have a gross annual household income not more than \$16,152 for a one-person household or \$21,828 for a two-person household.*

Household is defined as: you, your spouse (if he/she is living with you), and any dependent children aged 18 or younger who live with you. Household does not include any adults living in the house other than your spouse, nor any non-dependent children.

How to Enroll

- Fill out this enrollment form and provide supporting documentation, where required.
- If you are applying for yourself only, and you have a spouse who lives with you, you must also provide basic information about him or her, even if your spouse is not enrolling at this time.
- If you would like to be considered for premium assistance, or you are under age 65, you must provide proof of income as indicated in Section C.
- If your enrollment form is complete and you are eligible for the program, you will receive a written approval letter outlining the premium, deductible and co-payment rates that apply to you.
- If your enrollment form is incomplete, you will receive a telephone call, and a letter will be mailed to you with a request for additional information.
- If you are determined ineligible, you will receive a written explanation of the denial and information regarding your rights for review.
- Enrollment is open to all eligible persons through March 31, 2002. Those who are eligible now and do not apply by March 31, 2002, may have to wait to apply and may be subject to a surcharge. Please call customer service at the number below to receive more information about enrollment.
- If you have questions about this enrollment form, call Prescription Advantage at one of the numbers listed at the bottom of this page.
- Mail the completed, signed enrollment form, along with copies of the required documentation, to:

Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153

*Call for information on households larger than two persons.



Massachusetts, Now You're Covered.

1-800-AGE-INFO (1-800-243-4636) • www.800ageinfo.com
 TTY: 1-877-610-0241 (toll free) for the deaf and hard of hearing

Rate Schedule

This rate schedule is only a guide. Prescription Advantage will review your household income and will notify you of the rates that apply to you. These household income ranges will change on April 1 each year.* Rates are subject to change anytime.

Gross Annual Household Income

	One person household	\$0-16,152	\$16,153-17,184	\$17,185-19,332	\$19,333-21,480	\$21,481-25,776	\$25,777-34,368	\$34,369-42,960	\$42,961 Plus
	Two person household**	\$0-21,828	\$21,829-23,220	\$23,221-26,124	\$26,125-29,028	\$29,029-34,836	\$34,837-46,440	\$46,441-58,056	\$58,057 Plus
Retail Co-Pays (One Month Supply)									
Level 1: Generic Drugs		\$5	\$5	\$10	\$10	\$10	\$10	\$10	\$10
Level 2: Select Brand-Name Drugs		\$12	\$12	\$25	\$25	\$25	\$25	\$25	\$25
Level 3: Additional Brand-Name Drugs		50 % of Cost or \$ 25.00 , whichever is greater.							
Mail Order Co-Pays (Three Month Supply)									
Level 1: Generic Drugs		\$10	\$10	\$20	\$20	\$20	\$20	\$20	\$20
Level 2: Select Brand-Name Drugs		\$25	\$25	\$50	\$50	\$50	\$50	\$50	\$50
Level 3: Additional Brand-Name Drugs		50 % of Cost or \$ 50.00 , whichever is greater.							
Annual Deductible Per Enrollee									
		0	\$100	\$250	\$300	\$400	\$450	\$475	\$500
Annual Out-of-Pocket Limit Per Enrollee									
		\$ 2,000.00 or 10 % of Gross Annual Household Income , whichever is less.							
Monthly Premium Per Enrollee									
	Single	\$0.00	\$15.00	\$25.00	\$45.00	\$55.00	\$65.00	\$75.00	\$82.00
	Married	\$0.00	\$12.00	\$20.00	\$36.00	\$44.00	\$52.00	\$60.00	\$66.00

Revised July 2001

*Current income ranges are effective April 1, 2001

**If your household is greater than two persons, please call for Rate Schedule information.

Chart 6. Analysis of State Drug Assistance Options Under Federal Law

Model	"Best Price" Exemption?	Manufacturer Discounted Price?	Sub-ceiling Negotiation?	Duplicate Discount Problem?	Non-FAMP Problem?	Access Issues?
(A) State subsidy/rebate model	Yes	Yes, manufacturer sales price minus state rebate	No, unless state has sufficient leverage to negotiate supplemental rebates like California	Yes, if clients also receive discounted drugs from 340B providers	No, unless rebates are processed through wholesalers rather than paid directly to state	No, assuming adequate participation of retail pharmacies and clinically appropriate formularies
(B) PBM outsourcing	Unclear if manufacturer rebates are based on PBM's business beyond just state program	Yes, manufacturer sales price minus PBM rebate	No	Same as above	Same as above	Same as above
(C) Manufacturer ceiling price tied to FSS, etc.	Yes, if the program is state-funded	Yes, assuming that the ceiling price is enforceable without violating U.S. Constitution (e.g., Maine case)	No, unless state has sufficient leverage to negotiate supplemental rebates like California	Same as above	Same as above	Same as above
(D) 1115 waiver expanded benefit	Yes, although the legality of this model is being litigated (Vermont case)	Yes, Medicaid rebate discount	Same as above	Same as above	No	Same as above
(E) Pharmacy discounts	No	No	No	No	No	Same as above
(F) Buyer's club	No	Yes, plan's negotiated prices with manufacturers	No	Yes, if clients also receive discounted drugs from 340B providers	No	Same as above
(G) Bulk purchasing	Unclear if purchasing cooperative includes entities other than state-funded drug assistance programs	Yes, cooperative's negotiated prices with manufacturers	No	Same as above	Yes, unless negotiated discounts take the form of rebates paid directly to state	Same as above
(H) Steering clients to 340B covered entities	Yes	Yes, 340B ceiling price	Yes	Yes, if state also receives rebates for 340B-discounted drugs	Yes	Yes, unless mail order, contract pharmacy arrangements included and clinically appropriate formularies are used